IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

June 29, 2006

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642

Provider #: 135130

Dear Mr. Frasure:

On **June 5, 2006**, a Complaint Investigation was conducted at Aspen Transitional Rehabilitation. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 17 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001433

ALLEGATION #1:

The complainant stated the facility removed the safety alarms from the identified resident's bed and chair two days prior to the resident falling. The complainant stated the resident had a history of falls at night.

FINDINGS:

The identified resident's record was reviewed and it was determined the facility did not ensure safety measures were in place to minimize the risk of falls. The resident sustained a right hip fracture on May 22, 2006, requiring hospitalization.

The facility was cited at F324 for failure to provide adequate supervision to prevent falls. The facility was also cited at F280 for failure to review and revise resident's care plans.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the identified resident reported to a visitor that she had to wait 35-45 minutes for

her call light to be answered.

FINDINGS:

The identified resident was no longer in the facility at the time of the investigation. During the investigation there were 23 residents in the facility. Nine cognitively intact residents were interviewed. Each stated the staff was prompt to answer call lights on all shifts. The facility's resident/family grievances were reviewed from March through May 2006. There were no identified concerns regarding the timeliness of call lights being answered.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the identified resident fell at 12:30 a.m., (date not given.) Staff gave her a Tylenol but no other treatment was received. The resident was not sent to a local hospital for an x-ray until approximately 8:00 a.m. According to the complainant, a nurse at the hospital stated the resident's leg was three inches shorter than the other, which clearly indicated the hip was fractured.

FINDINGS:

The identified resident's closed record from the facility and the hospital Emergency Room records were reviewed.

The facility's incident/accident report and nurses' notes were reviewed. The following was documented: On May 22, 2006 at 12:15 a.m., "...CNA (certified nursing assistant) went to (resident's room and found her sitting on the floor next to her bed facing the head of her bed. CNA asked (resident) what happened and (resident) said she was going to get back into her bed after going to the restroom and fell to the floor. CNA found her sitting on her bottom, feet (and) legs out in front of her. Small skin tear on right upper arm (and) c/o (complains of) pain in right hip but was able to bear wt (weight) and refused any comfort meds (medications)..." The report documented that 650 milligrams of Tylenol had been given to the resident at 5:00 a.m., for increasing right hip discomfort. A physician's assistant had been notified of the fall at 6:30 a.m., and orders to obtain an x-ray of the right hip was received. Nursing notes documented the resident was assessed throughout the night and there was no evidence of displacement of the right hip during this time period. Frequent neurological checks and vital signs were performed which were within normal limits for this resident. The resident was transported to a local hospital at 8:15 a.m. She was admitted to the hospital due to a right hip fracture later that morning.

The Emergency Room record was reviewed. The following was documented by a physician:

"...She now has right hip pain that is worsened with movement and palpation. She states that her hip hurt throughout the night and she was not able to get out of bed this morning. She rates her pain as moderate at this time... Patient is awake, alert and appropriate; no focal sensory deficit; no focal motor deficit; muscle strength 5/5 bilaterally with good dorsiflexion and plantar flexion of both feet equally... Localized bony tenderness on palpation to the right posterior hip with some increased discomfort with

movement; all other extremities moving without difficulty; full unrestricted range of motion; no calf tenderness..."

The notes further documented, "...fell last night while getting into bed at about 8 p.m. She was assisted into bed and slept through the night. However, this morning pain was present... Progress Note: Actually of the right hip and pelvis is suggestive of a possible nondisplaced right hip fracture. In discussion with radiologist MRI (Magnetic Resonance Imagery) of the right hip was ordered to establish whether there was a fracture... MRI (Magnetic Resonance Imagery) confirmed the nondisplaced right hip fracture..."

The Emergency Room nurse's notes documented: "...Hip... The area is painful, normal in appearance and swollen. ROM (Range of motion) is limited secondary to pain. No deformity is present. No dislocation is found... Has purposeful movement of both upper extremities entire both lower extremities."

The facility's resident record documented the resident was immediately assessed and monitored throughout the night after the fall. The assessments did not reveal any obvious signs or symptoms of a hip or lower extremity fracture which would have warranted immediate physician notification. Due to the resident's increasing pain level in the right hip early that morning, the physician was notified at that time.

The Director of Nursing of the facility was interviewed. She indicated that had the resident presented at the time of the fall with obvious signs and symptoms of a hip fracture, the staff would have immediately notified the physician.

The Emergency Room record did not identify that an obvious hip fracture was present. Routine x-ray also could not confirm the fracture. A Magnetic Resonance Imagery was required to confirm the diagnosis of right hip fracture.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the facility's aides are not qualified. The complainant could not site any specific information in this regard.

FINDINGS:

During the investigation nine cognitively intact residents were interviewed. Each stated the nurse aides were all very good. The residents were comfortable receiving cares. There were no resident/family grievances regarding the lack of qualified nurse aides.

Random staff was interviewed as well as the staff development coordinator. They stated the new hires are precepted by experienced certified nursing assistants and evaluated and given on-site training whenever it is indicated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated a local hospital reported that the resident's heels were "mushy and raw" upon her admission to the hospital.

FINDINGS:

At the time of the investigation, the resident was no longer in the facility.

The identified resident's closed record was reviewed. The facility documented on May 19, 2006, that the resident's heels were "mushy." There was no documented evidence that the heels had deteriorated to a stage one pressure ulcer. The facility immediately initiated pressure relief devices for the heels while the resident was in bed.

The Emergency Room notes were reviewed. There was no documented evidence in the physician's examination notes or the nursing triage/assessment notes to indicate there were any problems with the resident's heels.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Marcia Key

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj

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FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8811

June 16, 2006

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642

Provider #: 135130

Dear Mr. Frasure:

On **June 5, 2006**, a Complaint Investigation survey was conducted at Aspen Transitional Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be an isolated deficiency that constitute actual harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 29, 2006**. Failure to submit an acceptable PoC by **June 29, 2006**, may result in the imposition of civil monetary penalties by **July 19, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 10, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 10, 2006**. A change in the seriousness of the deficiencies on **July 10, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 10, 2006** includes the following:

Denial of payment for new admissions effective **September 5, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 5, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 5, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **June 29, 2006**. If your request for informal dispute resolution is received after **June 29, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. BUILDING _____ B. WING _____	C 06/05/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN TRANSITIONAL REHAB	2867 E COPPER POINT DR MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the investigation survey were: Marcia Key, RN Team Coordinator Lisa Kaiser, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This plan of correction is submitted as required under Federal and State Regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. RECEIVED JUN 27 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6-26-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure a care plan was reviewed and revised to include current treatments and interventions. This affected one resident (#2). Findings include: 1. Resident #2 was admitted to the facility 2/7/06 with diagnoses which included status post cerebrovascular accident with significant flaccidity on the entire right side of her body, aphasia, macular degeneration, and depression. A fall assessment, dated 2/7/06, identified the resident was at moderate risk for falls. The plan was to initiate occupational and physical therapy.	F 280	F-280 Patient Specific: Patient number 2 has been discharged. Other Patients: All patient care plans have been updated in regards to alarms. Systemic Changes: The D.O.N. or weekend manager will audit all patients daily to ensure that the alarm care plans are accurate. Monitors: A daily monitor sheet has been implemented to ensure that Patients with alarms are care planned appropriately. Date of Compliance: 06/29/2006	

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F 280	Continued From page 2 The care plan identified that on 3/16/06, the facility placed safety alarms to her bed and wheelchair. Review of an incident/accident report, dated 4/24/06, documented the safety alarm had been discontinued the same day the resident fell from her wheelchair. The resident's "Falls" care plan was last updated on 3/23/06, which documented, "1. Alarms on as per order; 2. Notify MD prn [as needed]; 3. [Symbol for 2] person transfer mandatory." The DON was interviewed on 6/5/06 at 11:52 am. She acknowledged the care plan had not been updated to reflect the discontinuation of the safety alarm to the wheelchair.	F 280		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and a complaint from the public it was determined the facility did not ensure appropriate safety measures were in place to prevent falls. This resulted in harm to two residents (#1 and #2) who sustained falls which resulted in fractures and subsequent hospitalization. Findings include: 1. Resident #1 was admitted to the facility on 4/14/06 with diagnoses including nondisplaced right pubic ramus fracture, scalp hematoma,	F 324	F-324 Patient Specific: Patients numbers' 1 and 2 have been discharged.	

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F 324	Continued From page 3 history of recurrent falls, dizziness, lightheadness, weakness, hypertension, atrial fibrillation, and osteopenia. The facility's initial evaluation, dated 4/19/06, signed by the medical director and a physician's assistant, documented the resident was assessed with "1) Ataxia. Multifactorial including right hip pain, generalized weakness. History of multiple ground level falls. 2) Repeat hip pain, persistent since fall on 4/10/06." The facility's "Fall Risk Assessment" dated 4/14/06, documented the resident scored "9" which indicated she was at low risk for falls ("0-11 = Low Risk"). However, other documentation revealed she was at high risk for falls. The resident's admission MDS, dated 4/20/06, documented the resident required extensive physical assistance of one staff member for transferring, dressing, toileting, and locomotion on the unit. According to the MDS, the resident was not able to attempt a test for balance while standing without physical assistance and a wheelchair was her primary mode of locomotion. The resident's care plan, dated 5/3/06, documented a problem of "High risk for Falls related to: hx [history of] falls; [decreased] mobility." The short term goal identified for this problem was, "Patient will remain free from injury related to fall during the next 90 days" and the approaches were "Assist with transfers and ambulation as needed" and "Encourage patient to call for assistance with transfers and ambulation." Incident and accident reports for the resident	F 324	Other Patients: All patients have been re-evaluated for the need of alarms. Alarms are in place as ordered. Alarms are care planned. If alarms have been d/c'd rational has been documented and care planned. Systemic Changes: A daily alarm audit has been implemented which contains a check to ensure that a: alarms are in place as ordered, b: alarms are care planned, and c: if alarms are d/c'd the rational is documented appropriately. A separate patient alarm sheet has been	

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F 324	Continued From page 4 documented the following: *4/25/06 at 9:00 pm "Found laying on floor in front of her w/c [wheelchair] next to bed. Stated she didn't know what happened. Small rug burn abrasion on Rt. [right] knee [and] c/o [complaint of] pain on left rib cage." The report documented the incident was "Self Induced." The "Results of the Interdisciplinary Team Review" section of the report was blank. *5/1/06 at 8:20 pm "Pt. [patient] found sitting on the bathroom floor by one sink by CNA. States 'my w/c was not locked and I slid out of it.' W/C parked by the toilet locked. Pt. states 'I am ok, I did not hit anything.' [No] bruising noted at this time. [No] apparent injuries. ROM [range of motion] WNL [within normal limits] to all extremities." The report documented the findings as: "fall inflicted by self-transferring." The "Results of the Interdisciplinary Team Review" portion of the report documented: "repeated education to patient to not remove alarms and alert staff to transferring needs." *5/22/06 at 12:15 am "...CNA went to [resident #1's] room and found her sitting on the floor next to her bed facing the head of her bed. CNA asked [resident #1] what happened and [resident] said she was going to get back into her bed after going to the restroom and fell to the floor. CNA found her sitting on her bottom, feet [and] legs out in front of her. Small skin tear on Right upper arm [and] c/o pain in Right hip but was able to bear wt. [weight] and refused any comfort meds [medications]..." The report documented that 650 milligrams of Tylenol had been given to the resident at 5:00 am for increasing right hip	F 324	implemented which will be updated daily to facilitate communication to all staff members of the need of alarms for specific patients. Monitors: See systemic changes. Date of Compliance: 06/29/2006	

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F 324	Continued From page 5	F 324		

discomfort. A physician's assistant was notified of the fall at 6:30 am and orders to obtain an x-ray of the right hip were received. Nursing notes indicated the resident was assessed throughout the night and there was no evidence of displacement of the right hip. The resident was transported to a local hospital at 8:15 am. She was admitted to the hospital due to a right hip fracture later that morning.

Nursing notes documented the following information regarding alarms:

*5/2/06 4:10 pm "...alarm in place..."
*5/4/06 3:30 pm "...Tab alarm in place..."
*5/12/06 7:15 pm "...Tab alarm in place to alert staff of unassisted transfers..."
*5/13/06 "...Bed, w/c [wheel chair] tab alarm in place, to alert staff of unassisted transfers..."

An interview was conducted with the Administrator, the DON, the MDS Coordinator, and a corporate representative on 6/5/06 at 11:52 am regarding resident #1 and her history of falls in the facility. The DON stated alarms were put in place after the resident's fall on 4/25/06. She stated, "We didn't write it down..." According to the DON, the alarms were discontinued as they "irritated" the resident and in anticipation that "...she was going home soon..." The DON could not give an exact date the alarms were removed but stated she would check into it. At 1:51 pm, the DON stated, "...Therapies told the CNAs to DC [discontinue] the alarms but they didn't document it..." She further stated, "...If it's not documented it didn't happen..." The DON indicated that the occupational therapy department was working with the resident

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F 324	Continued From page 6 regarding transferring and safety issues. The DON stated the Interdisciplinary Team (IDT) had reviewed the resident's record in their weekly meeting and in anticipation of discharge, opted to discontinue the use of alarms as well. The resident's "Occupational Therapy Weekly Progress Summary," dated 5/17/06, was reviewed. The "Precautions:" portion of the form documented "fall risk" and in a column dated 5/17/06, the documentation included "safety problems." There was no documentation in the occupational therapy notes regarding the initiation, presence of or discontinuation of alarms for the resident's safety. The resident's IDT records were reviewed. The records indicated the resident had been reviewed by the committee for four consecutive weeks beginning 4/20/06 and ending on 5/11/06. None of the IDT records reviewed contained documentation regarding the initiation or the discontinuation of alarms for the resident's safety. The facility did not ensure that appropriate safety measures were in place for a resident with a documented history of recurrent falls. The resident's "Fall Risk Assessment" and her care plan were not updated to include interventions to prevent falls and protect the resident from injury even after she had fallen twice in the facility within six days. Nursing notes sporadically document the presence of an alarm from 5/2/06, one day after the resident's second fall, through 5/13/06, nine days before the resident's third fall that resulted in a fractured hip. The DON and other administrative staff acknowledged the alarms had been removed on an unknown date before the fall	F 324		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 7 of 5/22/06, as the resident would be discharged in the near future. There was no indication other measures had been implemented to prevent falls. This resulted in harm to the resident when she fell for the third time in the facility and sustained a right hip fracture requiring hospitalization. 2. Resident #2 was admitted to the facility 2/7/06 with diagnoses which included status post cerebrovascular accident with significant flaccidity on the entire right side of her body, aphasia, macular degeneration, and depression. A fall assessment, dated 2/7/06, identified the resident was at moderate risk for falls. The plan was to initiate occupational and physical therapy. The care plan identified that on 3/16/06, the facility placed safety alarms to her bed and wheelchair. Review of the facility's Patient Incident Reports documented that on 3/23/06 the resident's family member attempted to assist the resident to the bathroom. The family member could not support the resident and she lowered the resident to the floor. No injuries were sustained. On 4/24/06, at 8:30 pm, the resident fell out of her wheelchair while she was in her room. She sustained a right ankle fracture requiring hospitalization. The report documented the fall was unwitnessed. The facility conducted staff interviews. Two CNAs and one LN, who were in the staff breakroom, stated they responded when they heard the resident "yelling." According to the statements there was no alarm on the chair as the alarm had been discontinued that same day. The resident's closed record was reviewed. There	F 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135130	A. BUILDING _____ B. WING _____	C 06/05/2006

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F 324	Continued From page 8 was no documentation that the resident's safety was re-assessed by nursing or the therapy department prior to the discontinuation of the alarm. On 6/5/06 at approximately 4:00 pm, the DON was interviewed. She was asked to provide further documentation that the resident's safety was re-assessed prior to removal of the wheelchair alarm. She acknowledged there was no documented evidence how the facility determined the resident was no longer at risk for falls. The facility did not ensure that appropriate safety measures were in place for a resident who was identified as moderate risk for falls. The resident's care plan was not updated to include interventions to prevent falls and protect the resident from injury. The facility's failure to assess and supervise the resident resulted in harm when she sustained a right ankle fracture following a fall from her wheelchair.	F 324		

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the survey were: Marcia Key, RN Team Coordinator Lisa Kaiser, RN	C 000		
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F 280 as it addresses the facility's failure to revise care plans as indicated.	C 782	See P.O.C. for F280	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F 324 as it addresses the facility's failure to protect residents from accidents and injury.	C 790	See P.O.C. for F324	

RECEIVED
JUN 27 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6-26-06